

Department of Human Services  
Bureau of Human Service Licensing  
LICENSING INSPECTION SUMMARY - PUBLIC

December 10, 2024

[REDACTED]  
HERITAGE GROVE AT INDIANA LLC  
[REDACTED]

RE: HERITAGE GROVE AT INDIANA  
1703 WARREN ROAD  
INDIANA, PA, 15701  
LICENSE/COC#: 45516

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/16/2024, 10/17/2024, 10/21/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,  
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

**Facility Information**

**Name:** HERITAGE GROVE AT INDIANA      **License #:** 45516      **License Expiration:** 02/13/2025

**Address:** 1703 WARREN ROAD, INDIANA, PA 15701

**County:** INDIANA      **Region:** WESTERN

**Administrator**

**Name:** [REDACTED]      **Phone:** [REDACTED]      **Email:** [REDACTED]

**Legal Entity**

**Name:** HERITAGE GROVE AT INDIANA LLC

**Address:** [REDACTED]

**Phone:** [REDACTED]      **Email:** [REDACTED]

**Certificate(s) of Occupancy**

**Type:** C-2 LP      **Date:** 01/24/1994      **Issued By:** L&I

**Staffing Hours**

**Resident Support Staff:** 0      **Total Daily Staff:** 53      **Waking Staff:** 40

**Inspection Information**

**Type:** Partial      **Notice:** Unannounced      **BHA Docket #:**

**Reason:** Incident      **Exit Conference Date:** 10/21/2024

**Inspection Dates and Department Representative**

10/16/2024 - On-Site: [REDACTED]

10/17/2024 - Off-Site: [REDACTED]

10/21/2024 - Off-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

**License Capacity:** 80      **Residents Served:** 35

**Secured Dementia Care Unit**

**In Home:** Yes      **Area:** Memory Care      **Capacity:** 40      **Residents Served:** 11

**Hospice**

**Current Residents:** 2

**Number of Residents Who:**

**Receive Supplemental Security Income:** 1      **Are 60 Years of Age or Older:** 35

**Diagnosed with Mental Illness:** 1      **Diagnosed with Intellectual Disability:** 0

**Have Mobility Need:** 18      **Have Physical Disability:** 0

**Inspections / Reviews**

10/16/2024 Partial

**Lead Inspector:** [REDACTED]      **Follow-Up Type:** POC Submission      **Follow-Up Date:** 11/16/2024

Inspections / Reviews *(continued)*

11/20/2024 POC Submission

Submitted By: [REDACTED] Date Submitted: 12/06/2024  
Reviewer: [REDACTED] Follow Up Type: POC Submission Follow Up Date: 11/27/2024

12/02/2024 POC Submission

Submitted By: [REDACTED] Date Submitted: 12/06/2024  
Reviewer: [REDACTED] Follow Up Type: Document Submission Follow Up Date: 11/22/2024

12/10/2024 Document Submission

Submitted By: [REDACTED] Date Submitted: 12/06/2024  
Reviewer: [REDACTED] Follow Up Type: Not Required

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [REDACTED], at approximately 5:30 a.m., staff person A was attempting to assist resident [REDACTED] in getting dressed. Resident [REDACTED] did not want to get dressed, stating, "get the [REDACTED] out of here, I don't know why you are doing this to me," and was struggling against staff person A, who was trying to put resident [REDACTED]'s arms into [REDACTED] shirt. Staff person A then took resident [REDACTED] shirt and threw it, hitting resident [REDACTED] in the face. This was witnessed by staff person B and staff person C. This allegation of abuse was not reported in accordance with the Older Adult Protective Services Act until 10/13/24 at approximately 3:00 p.m.

Plan of Correction

Accept [REDACTED] - 11/20/2024)

Staff B alerted the director of wellness on [REDACTED] that there was something [REDACTED] wanted to discuss with [REDACTED] involving Resident [REDACTED] via text message. The director of wellness immediately informed the administrator. The administrator contacted Staff B via telephone to find out the details of the discussion Staff B wanted to have. As soon as the administration become aware of this situation, Staff B was reminded of the importance of reporting immediately. The Administrator did immediately make a verbal report to the Area Agency on Aging. The next day the director of wellness sent a report to the Department of Human Services. On 10/16/2024 all staff was educated on the Older Adult Protective Services Act. Employees not in attendance have met with administration one on one to be educated. Documentation has been kept. All employees were given a printed copy of the power point presentation for their own educational reference. To remind employees of the importance of immediate mandatory reporting signs will be posted in break rooms, near the time clock, and medication rooms. The signs will be hung by 11/22/24.

Licensee's Proposed Overall Completion Date: 11/22/2024

Implemented [REDACTED] - 12/10/2024)

16c - Written Incident Report

2. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [REDACTED], at approximately 5:30 a.m., staff person A was attempting to assist resident [REDACTED] in getting dressed. Resident [REDACTED] did not want to get dressed, stating, "get the [REDACTED] out of here, I don't know why you are doing this to me," and was struggling against staff person A, who was trying to put resident [REDACTED]'s arms into [REDACTED] shirt. Staff person A then took resident [REDACTED] shirt and threw it, hitting resident [REDACTED] in the face. This was witnessed by staff person B and staff person C. This incident was not reported to the Department until [REDACTED] at 4:38 p.m.

Plan of Correction

Accept [REDACTED] - 11/20/2024)

Staff B alerted the director of wellness on [REDACTED] that there was something [REDACTED] wanted to discuss with [REDACTED] involving Resident [REDACTED] via text message. The director of wellness immediately informed the administrator. The administrator contacted Staff B via telephone to find out the details of the discussion Staff B wanted to have. As soon as the administration become aware of this situation, Staff B was reminded of the importance of reporting

16c Written Incident Report (continued)

immediately. The Administrator did immediately make a verbal report to the Area Agency on Aging. The next day, 10/14/24 the director of wellness sent a report to the Department of Human Services. On 10/16/2024 all staff was educated on the Older Adult Protective Services Act. Employees not in attendance have met with administration one on one to be educated. Documentation has been kept. All employees were given a printed copy of the power point presentation for their own educational reference. To remind employees of the importance of immediate mandatory reporting signs will be posted in break rooms, near the time clock, and medication rooms. The signs will be hung by 11/22/24.

Licensee's Proposed Overall Completion Date: 11/22/2024

Implemented [redacted] - 12/10/2024)

42c - Treatment of Residents

3. Requirements

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

On [redacted], at approximately 5:30 a.m., staff person A was attempting to assist resident [redacted] in getting dressed. Resident [redacted] did not want to get dressed, stating, "get the [redacted] out of here, I don't know why you are doing this to me," and was struggling against staff person A, who was trying to put resident [redacted] arms into [redacted] shirt. Staff person A then took resident # [redacted]'s shirt and threw it, hitting resident [redacted] in the face. This was witnessed by staff person B and staff person C.

Plan of Correction

Accept [redacted] - 11/20/2024)

As soon as administration received this report from Staff B, Staff A was suspended pending investigation. All employees were educated on the Older Adult Protect Services Act. Upon conclusion of the Area Agency on Aging investigation as well as the facilities own internal investigation, Staff A was officially terminated from employment on 10/23/24. All employees will be educated again on resident rights at the next staff meeting currently scheduled for 11/22/2024. Documentation of education will be kept. Three resident interviews will be done every month for three months to make sure there are further incidents of resident rights violations.

Licensee's Proposed Overall Completion Date: 11/20/2024

Implemented [redacted] - 12/10/2024)